		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0038711

Facility Name: Embassy Care Center, Inc.

Address: 555 Kahler Road (Number) Wilmington (City) 60481 (Zip Code)

County: Will

Telephone Number: (815) 476-7931 **Fax #** (815) 476-7939

IDPA ID Number: 36-3863655-001

Date of Initial License for Current Owners: 02/01/93

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Bob Kagda **Telephone Number:** (847)-675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) Bob Kagda, Partner

(Firm Name & Address) Krupnick, Bokor, Kagda & Brooks, Ltd. 3750 W. Devon Ave. Lincolnwood, Il 60712-1124

(Telephone) (847)-675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	80	Skilled (SNF)	80	29,280	1
2		Skilled Pediatric (SNF/PED)			2
3	91	Intermediate (ICF)	91	33,306	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	171	TOTALS	171	62,586	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF		8,520	3,346	11,866	8
9	SNF/PED					9
10	ICF	26,083			26,083	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,083	8,520	3,346	37,949	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 60.63%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 02/01/93

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 16 and days of care provided 2,558

Medicare Intermediary Administar

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31 Fiscal Year: 12/31

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	211,524	13,364	8,038	232,926		232,926	(1,916)	231,010			1
2	Food Purchase		168,407		168,407	(19,076)	149,331	(15,652)	133,679			2
3	Housekeeping	172,881	23,214		196,095		196,095	(2,079)	194,016			3
4	Laundry	49,174	9,365		58,539		58,539	(839)	57,700			4
5	Heat and Other Utilities			111,435	111,435		111,435	(6,770)	104,665			5
6	Maintenance	30,192	7,678	40,802	78,672		78,672	(2,015)	76,657			6
7	Other (specify):*											7
8	**TOTAL General Services**	463,771	222,028	160,275	846,074	(19,076)	826,998	(29,271)	797,727			8
	B. Health Care and Programs											
9	Medical Director			6,394	6,394		6,394	(573)	5,821			9
10	Nursing and Medical Records	1,163,277	34,150	229,617	1,427,044		1,427,044	(23,684)	1,403,360			10
10a	Therapy	79,266	783	16,605	96,654		96,654	(11,366)	85,288			10a
11	Activities	103,743	2,703		106,446		106,446	(242)	106,204			11
12	Social Services	21,654		2,670	24,324		24,324	(239)	24,085			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,367,940	37,636	255,286	1,660,862		1,660,862	(36,104)	1,624,758			16
	C. General Administration											
17	Administrative	90,181		306,510	396,691		396,691	(259,257)	137,434			17
18	Directors Fees											18
19	Professional Services			51,719	51,719		51,719	(5,396)	46,323			19
20	Dues, Fees, Subscriptions & Promotions			16,330	16,330		16,330	(3,267)	13,063			20
21	Clerical & General Office Expenses	119,305	17,388	44,662	181,355		181,355	56,034	237,389			21
22	Employee Benefits & Payroll Taxes			347,058	347,058	19,076	366,134	(15,769)	350,365			22
23	Inservice Training & Education											23
24	Travel and Seminar			754	754		754	(68)	686			24
25	Other Admin. Staff Transportation			31,535	31,535		31,535	(29,906)	1,629			25
26	Insurance-Prop.Liab.Malpractice			162,139	162,139		162,139	(12,008)	150,131			26
27	Other (specify):*											27
28	**TOTAL General Administration**	209,486	17,388	960,707	1,187,581	19,076	1,206,657	(269,637)	937,020			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,041,197	277,052	1,376,268	3,694,517		3,694,517	(335,012)	3,359,505			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Embassy Care Center, Inc.
0038711
COST REPORT RECLASSIFICATIONS
01/01/04
12/31/04

SCHEDULE V LINE #			
22	EMPLOYEE BENEFITS	19,076	
2	FOOD		19,076

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX		
19	PROFESSIONAL FEES		

To reclass cost of appealing real estate taxes

Facility Name & ID Number Embassy Care Center, Inc. #0038711 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			44,561	44,561		44,561	101,565	146,126			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			50,805	50,805		50,805	462,540	513,345			32
33	Real Estate Taxes			62,005	62,005		62,005	6,254	68,259			33
34	Rent-Facility & Grounds			560,580	560,580		560,580	(560,580)				34
35	Rent-Equipment & Vehicles							865	865			35
36	Other (specify):*											36
37	**TOTAL Ownership**			717,951	717,951		717,951	10,644	728,595			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		86,914	77,961	164,875		164,875		164,875			39
40	Barber and Beauty Shops			1,757	1,757		1,757		1,757			40
41	Coffee and Gift Shops			658	658		658		658			41
42	Provider Participation Fee			93,879	93,879		93,879		93,879			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		86,914	174,255	261,169		261,169		261,169			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,041,197	363,966	2,268,474	4,673,637		4,673,637	(324,368)	4,349,269			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	16,118	30		9
10	Interest and Other Investment Income	(2)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(572)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(11,882)	21		18
19	Entertainment	(2,099)	20		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,269)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(265,991)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (265,697)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(58,671)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (58,671)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (324,368)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Embassy Care Center, Inc.

ID# 0038711

Report Period Beginning: 01/01/04

Ending: 12/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	From Embassy Building Partnership:	$		1
2	Trust Fees	(150)	21	2
3	Bank Charges	(632)	21	3
4	Non Patient Care - Interest Exp	(9,634)	32	4
5	R E Taxes	(4,339)	33	5
6	Mtgre Costs	(5,630)	32	6
7	Depreciation House	(3,846)	30	7
8	Depreciation - Section 754	(9,278)	30	8
9	Marketing Salaries	(23,394)	21	9
10	Marketing Expense	(439)	21	10
11	Bank Charges	(15,780)	21	11
12	Travel	(31,535)	25	12
13	Veterans Expense	(65)	10	13
14	Adjustment of Prior Periods:			14
15	Dietary	(1,916)	1	15
16	Food	(15,080)	2	16
17	Housekeeping	(2,079)	3	17
18	Laundry	(839)	4	18
19	Heat	(9,978)	5	19
20	Maintenance	(4,341)	6	20
21	Medicall Direcor	(573)	9	21
22	Nusrsing	(23,619)	10	22
23	Therapy	(1,557)	10a	23
24	Activities	(242)	11	24
25	Social Service	(239)	12	25
26	Administrative	(27,447)	17	26
27	Professional Fees	(4,631)	19	27
28	Dues	(1,462)	20	28
29	Clerical	(5,556)	21	29
30	Employee Benefits	(31,077)	22	30
31	Travel	(68)	24	31
32	Other Staff	(2,824)	25	32
33	**Ins**	(14,519)	26	33
34	Therapy	(9,809)	10a	34
35				35
36	Remove credit balance from Other Staff	2,824	25	36
37				37
38	Deferred Maintenance	(3,178)	6	38
39	Deferred Maintenance	1,745	6	39
40				40
41	Prior Year Legal bills Sachnoff etc	(775)	19	41
42	Prior Year Legal bills Neal etc	(4,029)	19	42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(265,991)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/04 Ending: 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses A. General Services	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
1	Dietary	(1,916)	0	0	0	0	0	0	0	0	0	0	(1,916)	1
2	Food Purchase	(15,652)	0	0	0	0	0	0	0	0	0	0	(15,652)	2
3	Housekeeping	(2,079)	0	0	0	0	0	0	0	0	0	0	(2,079)	3
4	Laundry	(839)	0	0	0	0	0	0	0	0	0	0	(839)	4
5	Heat and Other Utilities	(9,978)	0	3,208	0	0	0	0	0	0	0	0	(6,770)	5
6	Maintenance	(5,774)	0	3,759	0	0	0	0	0	0	0	0	(2,015)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(36,238)	0	6,967	0	0	0	0	0	0	0	0	(29,271)	8
	B. Health Care and Programs													
9	Medical Director	(573)	0	0	0	0	0	0	0	0	0	0	(573)	9
10	Nursing and Medical Records	(23,684)	0	0	0	0	0	0	0	0	0	0	(23,684)	10
10a	Therapy	(11,366)	0	0	0	0	0	0	0	0	0	0	(11,366)	10a
11	Activities	(242)	0	0	0	0	0	0	0	0	0	0	(242)	11
12	Social Services	(239)	0	0	0	0	0	0	0	0	0	0	(239)	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(36,104)	0	0	0	0	0	0	0	0	0	0	(36,104)	16
	C. General Administration													
17	Administrative	(27,447)	0	(231,810)	0	0	0	0	0	0	0	0	(259,257)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(9,435)	0	4,039	0	0	0	0	0	0	0	0	(5,396)	19
20	Fees, Subscriptions & Promotions	(3,561)	150	144	0	0	0	0	0	0	0	0	(3,267)	20
21	Clerical & General Office Expenses	(59,102)	786	114,350	0	0	0	0	0	0	0	0	56,034	21
22	Employee Benefits & Payroll Taxes	(31,077)	0	15,308	0	0	0	0	0	0	0	0	(15,769)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(68)	0	0	0	0	0	0	0	0	0	0	(68)	24
25	Other Admin. Staff Transportation	(31,535)	0	1,629	0	0	0	0	0	0	0	0	(29,906)	25
26	Insurance-Prop.Liab.Malpractice	(14,519)	0	2,511	0	0	0	0	0	0	0	0	(12,008)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(176,744)	936	(93,829)	0	0	0	0	0	0	0	0	(269,637)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(249,086)	936	(86,862)	0	0	0	0	0	0	0	0	(335,012)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/04 Ending: 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	2,994	88,140	10,431	0	0	0	0	0	0	0	0	101,565	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(15,266)	470,503	7,303	0	0	0	0	0	0	0	0	462,540	32
33	Real Estate Taxes	(4,339)	4,339	6,254	0	0	0	0	0	0	0	0	6,254	33
34	Rent-Facility & Grounds	0	(560,580)	0	0	0	0	0	0	0	0	0	(560,580)	34
35	Rent-Equipment & Vehicles	0	0	865	0	0	0	0	0	0	0	0	865	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(16,611)	2,402	24,853	0	0	0	0	0	0	0	0	10,644	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(265,697)	3,338	(62,009)	0	0	0	0	0	0	0	0	(324,368)	45

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Schedule		See Schedule	See Schedule	See Schedule		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 560,580	Embassy Care LLC		$	$ (560,580)	1
2	V	20	Licenses & Fees		Embassy Care LLC		150	150	2
3	V	21	Bank Charges		Embassy Care LLC		632	632	3
4	V	21	Trust Fees		Embassy Care LLC		150	150	4
5	V	32	Interest Expense		Embassy Care LLC		464,673	464,873	5
6	V	33	RE Tax		Embassy Care LLC		4,339	4,339	6
7	V	30	Depreciation		Embassy Care LLC		88,140	88,140	7
8	V	32	Amort Mtge Costs		Embassy Care LLC		5,630	5,630	8
9	V	21	Office		Embassy Care LLC		4	4	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 560,580			$ 563,718	$ * 3,338	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Management Fees	$ 306,510	Future Associates		$	$ (306,510)	15
16	V	5	Utilities		Future Associates		3,208	3,208	16
17	V	6	Maintenance		Future Associates		3,759	3,759	17
18	V	17	Administrative		Future Associates		74,700	74,700	18
19	V	19	Professional Fees		Future Associates		4,039	4,039	19
20	V	21	Clerical and General		Future Associates		114,350	114,350	20
21	V	22	Employee Benefits		Future Associates		15,308	15,308	21
22	V	25	Auto Expense		Future Associates		1,629	1,629	22
23	V	26	Insurance Expense		Future Associates		2,511	2,511	23
24	V	30	Depreciation		Future Associates		10,431	10,431	24
25	V	32	Interest Expense		Future Associates		7,303	7,303	25
26	V	33	Real Estate Taxes		Future Associates		6,254	6,254	26
27	V	35	Equipment Rental		Future Associates		865	865	27
28	V	20	License, Dues, Fees		Future Associates		144	144	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 306,510			$ 244,501	$ * (62,009)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Haim Perlstein	Director	Administrative	22.96	See attached	27	45.00	Admin	$ 74,700	17-7	1
2											2
3	Nachshon Draiman	Director	Administrative	70.40							3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 74,700		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Future Associates
Street Address: 7514 N. Skokie Blvd
City / State / Zip Code: Skokie, Il
Phone Number: (847)982-1195
Fax Number: (847)982-0992

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Management Fees	1,044,567	3	$ 10,933	$	306,510	$ 3,208	1
2	6	Maintenance	Management Fees	1,044,567	3	12,811		306,510	3,759	2
3	17	Administrative	Direct allocation		3	326,600			74,700	3
4	19	Professional Fees	Management Fees	1,044,567	3	13,763		306,510	4,039	4
5	21	Clerical and General	Management Fees	1,044,567	3	389,695	332,310	306,510	114,349	5
6	22	Employee Benefits	Management Fees	1,044,567	3	52,169		306,510	15,308	6
7	25	Auto Expense	Management Fees	1,044,567	3	5,551		306,510	1,629	7
8	26	Insurance Expense	Management Fees	1,044,567	3	8,556		306,510	2,511	8
9	30	Depreciation	Management Fees	1,044,567	3	35,549		306,510	10,431	9
10	32	Interest Expense	Management Fees	1,044,567	3	24,887		306,510	7,303	10
11	33	Real Estate Taxes	Management Fees	1,044,567	3	21,313		306,510	6,254	11
12	35	Equipment Rental	Management Fees	1,044,567	3	2,948		306,510	865	12
13	20	License, Dues, Fees	Management Fees	1,044,567	3	491		306,510	144	13
14	21	Clerical and General	Direct allocation		4	48,897	48,897		0	14
15	22	Employee Benefits	Direct allocation		4	3,885			.	15
16										16
17		Round off adj							1	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 958,048	$ 381,207		$ 244,501	25

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	CIB Bank		X	Mortgage	$43,220.44	12/30/99	$ 4,510,000	$		9.7500	$ 426,890	1
2	RE Taxes										4,744	2
3	Payroll Taxes										13	3
4	IDPA										7,029	4
5	Allocation from Future										7,303	5
	Working Capital											
6	State Financial		X	Working Capital						Various	28,349	6
7	CIB Bank		X	Working Capital	Dec-99					Various	32,210	7
8	Insurance		X								6,809	8
9	TOTAL Facility Related				$79,715.44		$ 4,510,000	$			$ 513,347	9
	B. Non-Facility Related*											
10	Interest Income											10
11	House										9,634	11
12	Adjust out House										(9,634)	12
13	Interest Income										(2)	13
14	TOTAL Non-Facility Related						$	$			$ (2)	14
15	TOTALS (line 9+line14)						$ 4,510,000	$			$ 513,345	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 64,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$ (64,000)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 132,259	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 68,259	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	54,781	8
	2000	56,677	9
	2001	60,323	10
	2002	63,352	11
	2003	63,005	12
Estimate based on 2003 bill adjusted to	63000		
Allocation from Future	6254		

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Embassy Care Center, Inc. COUNTY Will

FACILITY IDPH LICENSE NUMBER 0038711

CONTACT PERSON REGARDING THIS REPORT Bob Kagda

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	03-17-36-300-010-0000	Nursing Home	$ 63,005.00	$ 63,005.00
2.	10-28-408-025	Management Office	$ 19,504.30	$ 1,626.00
3.	10-28-408-026	Management Office	$ 9,526.97	$ 794.00
4.	10-28-408-027	Management Office	$ 9,526.97	$ 794.00
5.	10-28-408-028	Management Office	$ 13,827.82	$ 1,153.00
6.	10-28-408-029	Management Office	$ 13,827.82	$ 1,153.00
7.	10-28-408-030	Management Office	$ 1,657.06	$ 138.00
8.	10-28-408-031	Management Office	$ 1,657.06	$ 138.00
9.			$	$
10.			$	$
		TOTALS	$ 132,533.00	$ 68,801.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 40,500 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1993	$ 145,000	1
2					2
3	TOTALS			$ 145,000	3

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	171		1993		$ 2,363,000	$ 75,016	35	$ 67,514	$ (7,502)	$ 804,542	4
5											5
6	Alloc LCF			1986	63,773	2,678	19-30	2,126	(552)	49,433	6
7	Alloc LCF			1987	1,530	49	31.5	49		850	7
8											8
	Improvement Type**										
9	Various			1993	55,674	1,097	20	2,784	1,687	31,913	9
10	Various			1994	144,492	2,930	20	7,220	4,290	76,143	10
11	Various			1995	126,250	3,224	20	6,309	3,085	59,754	11
12	Various			1996	94,458	2,422	20	4,720	2,298	40,419	12
13	Various			1997	13,974	359	20	698	339	5,480	13
14	Various			1998	13,694	219	20	685	466	4,384	14
15	Various			1999	29,626	762	20	1,481	719	7,966	15
16	Various			2000	68,597	608	20	3,597	2,989	14,713	16
17	Alarm system			7/31/01	1,691	43	20	85	42	297	17
18	Sewer rodding			11/5/01	1,265	32	20	63	31	200	18
19	Wire fire alarm system			11/12/01	756	20	20	19	(1)	64	19
20	CCTV service			11/12/01	945	25	20	48	23	150	20
21	Alarm system			2/27/02	1,466	38	20	74	36	208	21
22	Exterior sewer connection			1/24/03	8,498	218	20	425	207	637	22
23	Rooftop Htg. Unit Module			2/24/03	768	20	20	39	19	58	23
24	Rooftop compressor unit			5/17/03	1,250	32	20	63	31	94	24
25	Hood suppression system			6/6/03	1,489	38	20	75	37	112	25
26	CCTV monitoring system			6/23/03	1,409	36	20	71	35	106	26
27	New roof			7/29/03	25,000	641	20	1,250	609	1,875	27
28	New roof			10/31/03	20,000	513	20	1,000	487	1,000	28
29	Plastering & Painting			11/12/03	8,052	206	20	403	197	403	29
30	Smoke detectors, door holders			11/28/03	805	20	20	40	20	60	30
31	West wing toilet repairs			1/23/04	855	21	20	21		21	31
32	West wing sewer reairs			1/26/04	532	13	20	13		13	32
33	Voltage regulator tray			2/28/04	1,561	35	20	39	4	39	33
34	Broken water line			3/13/04	1,700	35	20	43	8	43	34
35	Clean outside manhole			4/14/04	1,413	26	20	35	9	35	35
36	Fire alarm service			5/5/04	1,658	27	20	41	14	41	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	A/C replaced roof compressor	5/20/04	$ 3,410	$ 55	20	$ 85	$ 30	$ 85	37
38	Access control panel	5/21/04	1,205	19	20	30	11	30	38
39	Tel & comp lines to network	5/21/04	786	13	20	20	7	20	39
40	Inoized smoke detectors	5/21/04	1,163	19	20	29	10	29	40
41	Roof work	7/19/04	37,177	437	20	929	492	929	41
42	Replaced tranformer on rooftop unit	7/19/04	1,082	13	20	27	14	27	42
43	Ran E.M.T. and cables	8/2/04	846	8	20	21	13	21	43
44	Compressor	9/29/04	2,900	22	20	73	51	73	44
45	Repair exit door alarm;rooftop cam	12/1/04	1,287	12	20	32	20	32	45
46	Heat exchanger	12/1/04	1,658	2	20	41	39	41	46
47	Heat exchanger	12/1/04	1,732	2	20	43	41	43	47
48	Heat exchanger	1/18/04	3,200	79	20	80	1	80	48
49	Allocation from LCF	1987	8,777	279	31.5	279		4,806	49
50	Allocation from LCF	1988	493	16	31.5	16		256	50
51	Allocation from LCF	1989	183	6	31.5	6		89	51
52	Allocation from LCF	1993	5,098	131	39	131		1,486	52
53	Allocation from LCF	1994	7,774	199	39	199		2,084	53
54	Allocation from LCF-Air Cond; Roof repairs	2001	2,165	55	39	55		150	54
55	Allocation from LCF-5 Ton Trane A/C	2002	531	13	39	13		32	55
56	Allocation from LCF-Office Remodeling	2003	322	8	39	8		8	56
57	Allocation from LCF-Electrical	2004	1,116	24	39	24		24	57
58	Allocation From Future	1987	27,661	878	31.5	893	15	15,959	58
59	Allocation From Future	1994	8,090	110	Var	110		4,963	59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,174,837	$ 93,803		$ 104,174	$ 10,371	$ 1,132,320	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 299,393	$ 25,796	$ 30,334	$ 4,538	10	$ 182,463	71
72	Current Year Purchases	6,167	1,378	309	(1,069)	10	309	72
73	Fully Depreciated Assets	547,202	57	4,585	4,528	10	547,202	73
74								74
75	TOTALS	$ 852,762	$ 27,231	$ 35,228	$ 7,997		$ 729,974	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Bus		6/16/1998	$ 1,200	$	$	$		$ 1,200	76
77	Van	Dodge Caravan	4/7/2003	18,750	6,000	3,750	(2,250)		5,625	77
78	Allocation from Future			79,780	2,974	2,974			40,257	78
79										79
80	TOTALS			$ 99,730	$ 8,974	$ 6,724	$ (2,250)		$ 47,082	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,272,329	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 130,008	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 146,126	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 16,118	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,909,376	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	House	$ 150,000	$ 3,846	$ 33,492	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 150,000	$ 3,846	$ 33,492	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/04 Ending: 12/31/04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ ____ Description: ____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocation from Future		$	$ 865	17
18					18
19					19
20					20
21	TOTAL		$	$ 865	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

[ ] YES
[X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER AIDE ____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 30,799	$		$ 30,799	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			4,676			4,676	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			37,889			37,889	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				76,369		76,369	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					4,597	10,545		15,142	13
14	TOTAL			$		$ 77,961	$ 86,914		$ 164,875	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Special Services - Supplies - (Column 6 -Other)

1	Medical Supplies	39-2
2	Equipment Rental	39-2
	Total	

Outside Therapies (Column 5- Other)

1	Medical Other Expense	39-3
2	Lab & XRay	39-3
	Total	

01/01/04 to 12/31/04

10545
10545

450
4147
4597

STATE OF ILLINOIS

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/04 Ending: 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 7,339	$ 10,867	1
2	Cash-Patient Deposits	45,086	45,086	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 110,000)	760,879	775,494	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	183,462	183,462	6
7	Other Prepaid Expenses	3,758	3,758	7
8	Accounts Receivable (owners or related parties)	1,961,626	5,092,161	8
9	Other(specify): See schedule	37,300	46,504	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,999,450	$ 6,157,332	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		149,058	13
14	Buildings, at Historical Cost		2,874,827	14
15	Leasehold Improvements, at Historical Cost	591,064	591,064	15
16	Equipment, at Historical Cost	406,624	798,624	16
17	Accumulated Depreciation (book methods)	(479,808)	(1,865,721)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See schedule	25,278	112,469	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 543,158	$ 2,660,321	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,542,608	$ 8,817,653	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,326,648	$ 1,507,420	26
27	Officer's Accounts Payable	3,276,009	3,276,009	27
28	Accounts Payable-Patient Deposits	39,862	39,862	28
29	Short-Term Notes Payable	418,667	797,249	29
30	Accrued Salaries Payable	167,571	167,571	30
31	Accrued Taxes Payable (excluding real estate taxes)	53,984	53,984	31
32	Accrued Real Estate Taxes(Sch.IX-B)	126,005	130,008	32
33	Accrued Interest Payable	7,930	47,782	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,416,676	$ 6,019,885	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		109,248	39
40	Mortgage Payable		4,053,335	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 4,162,583	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,416,676	$ 10,182,468	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,874,068)	$ (1,364,815)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,542,608	$ 8,817,653	48

*(See instructions.)

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,738,275)	1
2	Restatements (describe):		2
3	Round off adj	1	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,738,274)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(135,794)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (135,794)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,874,068)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,295,545	1
2	Discounts and Allowances for all Levels	(170,997)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,124,548	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	156,244	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 156,244	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,160	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	83,273	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	28,716	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 114,149	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See schedule	142,900	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 142,900	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,537,843	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	846,074	31
32	Health Care	1,660,862	32
33	General Administration	1,187,581	33
	B. Capital Expense		
34	Ownership	717,951	34
	C. Ancillary Expense		
35	Special Cost Centers	167,290	35
36	Provider Participation Fee	93,879	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,673,637	40
41	**Income before Income Taxes (line 30 minus line 40)****	(135,794)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (135,794)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

STATE OF ILLINOIS

Facility Name & ID Number Embassy Care Center, Inc. # 0038711

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES As of 12/31/04

OTHER CURRENT ASSETS:	Amount	Amount
Real Estate Tax Escrow	22,073	31,277
Employee Advances	2,709	2,709
Deferred Income Taxes	12,518	12,518
	37,300	46,504

OTHER NON CURRENT ASSETS:		
Construction In Progress		
Deposit	3,478	3,478
Loan Costs	21,800	108,991
Exchange		
	25,278	112,469

Report Period Beginning: 01/01/04 Ending: 12/31/04

OTHER CURRENT LIABILITIES:	Amount	Amount
Accrued Expenses		

OTHER NON CURRENT LIABILITIES:

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,312	1,388	$ 36,034	$ 25.96	1
2	Assistant Director of Nursing	1,774	1,984	48,720	24.56	2
3	Registered Nurses	4,903	5,490	116,323	21.19	3
4	Licensed Practical Nurses	17,851	19,553	375,219	19.19	4
5	Nurse Aides & Orderlies	55,187	59,052	586,981	9.94	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,776	5,531	79,266	14.33	8
9	Activity Director	3,594	4,342	44,072	10.15	9
10	Activity Assistants	8,430	9,047	69,935	7.73	10
11	Social Service Workers	860	941	11,390	12.10	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,154	23,982	211,524	8.82	15
16	Dishwashers					16
17	Maintenance Workers	3,301	3,686	30,192	8.19	17
18	Housekeepers	20,876	22,748	172,881	7.60	18
19	Laundry	6,027	6,830	49,174	7.20	19
20	Administrator	3,388	3,826	90,181	23.57	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,569	10,448	95,911	9.18	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Marketing	1,525	1,541	23,394	15.18	33
34	TOTAL (lines 1 - 33)	164,527	180,389	$ 2,041,197 *	$ 11.32	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	156	$ 8,038	1-3	35
36	Medical Director	Monthly	6,394	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,350	10-3	39
40	Physical Therapy Consultant	81	15,971	10a-3	40
41	Occupational Therapy Consultant	17	634	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	47	2,670	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	301	$ 35,057		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,468	$ 56,646	3-10-3	50
51	Licensed Practical Nurses	2,346	76,516	3-10-3	51
52	Nurse Aides	4,819	95,105	3-10-3	52
53	TOTAL (lines 50 - 52)	8,633	$ 228,267		53

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sandra Juhl	Admin	0	$ 11,576
Barb Faron			3,938
Ellen Boulnois			39,659
Robert Maddox			20,764
Charlie Shorter			12,500
Year end Accrual Adjustment			1,744
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 90,181

B. Administrative - Other

Description	Amount
Future Associates	$ 306,510
TOTAL (agree to Schedule V, line 17, col. 3)	$ 306,510
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Krupnick,Bokor, Kagda, & Brooks	Acctg	$ 2,000
L J Cohn	Acctg	15,278
R Peelo	Medicare Acctg	4,200
Neal, Gerber & Eisenberg	Legal	4,679
Sachnoff & Weaver LTD	Legal	3,905
Personnel Planners	UC Con	1,179
Ins Cons	Ins	3,500
Various	Data Processing	16,539
Marketing	Marketing	439
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 51,719

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 90,909
Unemployment Compensation Insurance	17,926
FICA Taxes	156,152
Employee Health Insurance	55,706
Employee Meals	19,076
Illinois Municipal Retirement Fund (IMRF)*	
Employee Life Insurance	26,365
Allocation from Future	15,308
Adjustment of prior period expenses	(31,077)
TOTAL (agree to Schedule V, line 22, col.8)	$ 350,365

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	10,063
Health Care Worker Background Check	
(Indicate # of checks performed 222)	2,659
Advertising	
Dues and Subscriptions	362
Entertainment and Meals	2,099
Licenses and Fees	1,297
Allocation from Future	144
Adj of Prior year Exp	(1,462)
Less: Public Relations Expense	( )
Non-allowable advertising	(2,099)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,063

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	754
Adj of Prior year Exp	(68)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 686

**See instructions.

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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	Painting & Decorating	6/01	$ 2,347	3	$ 391	$ 782	$ 782	$ 392	$	$	$	$	$
2	Painting & Decorating	6/02	1,781	3		297	594	593	297				
3	Painting & Decorating	6/03	690	3			115	230	230	115			
4	Painting & Decorating	6/04	3,178	3				530	1,059	1,059	530		
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 7,996		$ 391	$ 1,079	$ 1,491	$ 1,745	$ 1,586	$ 1,174	$ 530	$	$

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/04 Ending: 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **75** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? **No** YES NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **93,879**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **11,854**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **n/a**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.